State of California—Health and Human Services Agency

Department of Health Services

[redacted]

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

7

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NUMBER | L.A. CODE

BIRTH DATE Month Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Month Day Year

Ethnic Code: 1—American Indian, 2—Asian, 3—Black, 4—Filipino, 5—Mexican American Hispanic, 6—White, 7—Other, 8—Pacific Islander

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE NUMBER) (CITY) (ZIP CODE)

CHDP ASSESSMENT

Indicate outcome for each Screening procedure

	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Follow-up Code in Appropriate Column: NEW C	PROBLEM SUSPECTED: KNOWN D	DATE OF SERVICE Month Day Year / FEES
01 HISTORY AND PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION					
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					12

FOLLOW-UP CODES

1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED.
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED.

REFERRED TO | TELEPHONE NUMBER

REFERRED TO | TELEPHONE NUMBER

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA.

CODE	OTHER TESTS—PLEASE REFER TO THE CHDP LIST OF TEST CODES	CODE	OTHER TESTS

HEIGHT IN INCHES 0 4 | WEIGHT Pounds Ounces | BLOOD PRESSURE

HEMOGLOBIN . | HEMATOCRIT .0% | BIRTH WEIGHT Pounds Ounces

ROUTINE REFERRAL(S) (✓) ☐ BLOOD LEAD ☐ DENTAL | PATIENT IS A FOSTER CHILD (✓) ☐

ICD 9 CODES 1 2 3

IMMUNIZATIONS

PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D

THE QUESTIONS BELOW MUST BE ANSWERED.

	Yes	No
1. Is patient exposed to passive (second-hand) tobacco smoke?	☐	☐
2. Is tobacco used by patient?	☐	☐
3. Is patient counseled about/referred for tobacco use prevention/cessation?	☐	☐

PATIENT VISIT (✓): 1 ☐ New Patient or Extended Visit 2 ☐ Routine Visit

TYPE OF SCREEN (✓): 1 ☐ Initial 2 ☐ Periodic

TOTAL FEES

PROVIDER OF SERVICE: Name, address, telephone number (please include area code)

PROVIDER NUMBER

1 ☐ Enrolled in WIC 2 ☐ Referred to WIC

NOTE: WIC requires Ht., Wt., and Hemoglobin/Hematocrit

1 ☐ PARTIAL SCREEN 2 ☐ SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY COUNTY AID IDENTIFICATION NUMBER

1 ☐ If covered by Medi-Cal or preenrolled in CHDP Gateway, enter BIC number above.

2 ☐ Patient eligible for CHDP benefits only.

SITE OF SERVICE IF OTHER THAN ABOVE:

This is to certify that the screening information is true and complete, and the results explained to the child or his/her parent or guardian. I understand that payment and satisfaction of this claim may be from federal or state funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable federal or state law. I also certify that none of the services billed on this form have been or will be billed to Medi-Cal, the patient, or other insurance providers.

SIGNATURE OF PROVIDER | DATE

STATE OF CALIFORNIA—CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

COPY 1—MAIL TO MEDI-CAL CHDP

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

CONFIDENTIAL SCREENING/BILLING REPORT

PM 160 (7/03)

RELEASE OF INFORMATION NOTICE TO THE RESPONSIBLE PERSON:

The information provided on this form is voluntary and is used by the California Child Health and Disability Prevention (CHDP) program in accordance with Article 7, Subchapter 13, Title 17, of the California Administrative Code to monitor program quality, to reimburse providers of health assessments for their services, and to facilitate diagnosis and treatment at the local level for children found to have health problems. Information provided may be transferred to local health departments for follow-ups. Refusal to supply the information requested will hamper efforts to monitor this program, may delay reimbursement procedures, and may delay diagnosis and treatment of health conditions affecting your child. For access to records containing this information, you may contact the individual listed below. You may also request the location of this information and the categories of persons who use it.

Chief, Children's Medical Services Branch
Primary Care and Family Health Division
Department of Health Services
P.O. Box 942732
Sacramento, CA 94234-7320

(916) 327-1400